STATE OF RHODE ISLAND

DEPARTMENT OF HUMAN SERVICES

CENTER FOR CHILD AND FAMILY HEALTH

CERTIFICATION STANDARDS FOR PROVIDERS

CHILD AND ADOLESCENT INTENSIVE TREATMENT SERVICES

July 25, 2008

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1.0 Background Information

In July 2007, the Rhode Island General Assembly required the Department of Human Services (DHS) to administer process and pay Medicaid claims for Children's Intensive Services (CIS). Subsequent interdepartmental discussions between the Department of Children, Youth and Families (DCYF) and DHS as well as community-based providers have continued to focus on the management of services for children with serious emotional and/or behavioral disturbances (SED), with CIS representing just one component of the continuum of care.

Throughout the summer of 2007, DHS held site visits with all provider-agencies of CIS as well as discussions with DCYF clinical reviewers. This process enabled DHS to review administrative as well as clinical services for CIS. In November of 2007, DHS took over the clinical review and authorization process for CIS referrals from DCYF. This transfer required a different process of CIS notification and approval than was previously in place for provider-agencies with DCYF; claim adjudication has remained with Electronic Data Systems (EDS). EDS is the fiscal agent for DHS; it adjudicates all claims in accordance with DHS and Federal Medicaid policy and program rules.

CIS has existed as a fee-for-service Medicaid service outside of the scope of the RIte Care and RIte Share program. Responsibility for the management and administration of CIS moved from DCYF to DHS in July 2007. Effective August 1 2008, DHS will administer the CIS program under a new name: Child and Adolescent Intensive Treatment Services (CAITS). DHS anticipates that the CAITS program will become an in-plan service provided by RIte Care Health Plans within the first quarter of the 2009 calendar year. The movement of this program into RIte Care and RIte Share continues to involve Federal and State planning with RIte Care Health Plans (i.e., Blue Cross Blue Shield, Neighborhood Health Plan and United Health Care).

1.1 Introduction

These Certification Standards for Child and Adolescent Intensive Treatment Services (CAITS) serve to assemble all program requirements in order for DHS to provide the necessary oversight, quality assurance, and accountability for services. The provisions of this document set forth service requirements for CAITS and supercede all previous guidelines, verbal and written, and replace the 2003 Certification Standards for CIS.

These Certification Standards serve to provide families, service providers, potential applicants and other interested parties with a full description of CAITS, including guidance as to certification requirements and methods of application. Sections 1 through 6 contain service description and background as follows:

Section 1: Introduction, Service Overview, and Family Centered Philosophy
Section 2: Target Population and Service Requirements
Section 3: Service Authorization
Section 4: Certification Standards
Section 5: Provider Organization of Standards, and

Section 6: Qualified Entity Requirements.

1.2 Service Description and Definition

CAITS is a short-term acute behavioral health service available for up to 16 weeks per 12-month period. It is designed to provide intensive treatment to children and youth with moderate to severe emotional and/or behavioral disturbance. Medically necessary services (See Appendix 1) are delivered both in the child and adolescent's home and/or community settings. Essential to improved outcomes is the consistent and active participation of families throughout a child or youth's course of care. Treatment is focused on improving parent-child relations as well as developing parent knowledge and skills to improve the child's functioning.

CAITS is a behavioral health intervention informed by the scientific literature regarding how best to provide intensive clinical treatment services that are designed to reduce the likelihood of inpatient psychiatric hospitalization or residential treatment. These services are delivered in a timely manner in order to stabilize the at risk behaviors of children and adolescents. There will be no catchment areas or waiting lists. If, due to unanticipated high demands, a CAITS provider is unable to see a child and family within the required timeframe, it is the responsibility of the CAITS provider to coordinate care with another CAITS provider to ensure immediate access to care within the timeframes specified in these standards.

Throughout the course of care, CAITS supports the transition of children, adolescents, and their families to traditional outpatient behavioral health care services or to other appropriate services as needed. A critical component for RIte Care eligible children receiving CAITS is ongoing collaboration regarding the treatment and discharge planning with RIte Care Health Plans as well as well as collaboration with services covered by other health plans (e.g., for RIte Share enrollees).

1.3 Family Centeredness, Client Rights, and Ethical Standards of Practice

1.3.1 Family Centeredness

Providers must incorporate key components of family-centered care into their philosophy, service program and operations. Areas of program policy shall include, but are not limited to, the following:

1) Each child and family has the right to refuse care.

2) Each child and family has the right to choose a CAITS provider-agency from certified providers.

3) Each CAITS provider-agency is required to provide a list of all certified CAITS providers to the child and family.

4) Each CAITS provider-agency must have established arrangements for ongoing communication with, and participation of the family in all aspects of the treatment program.

5) Each CAITS provider-agency must have procedures in place describing family involvement in care planning.

6) Each CAITS provider-agency must have standards for working with the family and the caregivers to help them safely maintain the child at home.

7) Each CAITS provider-agency must have descriptions of service arrangements flexible enough to meet special and individual needs of the child/family receiving treatment.

8) Each CAITS provider-agency must assure that families can voice concerns and provide input.

9) Each CAITS provider-agency is required to inform families, in family friendly language, of their rights to the appeal process.

10) Each CAITS provider-agency should provide services in a culturally competent and sensitive manner. DHS encourages CAITS provider-agencies to develop culturally diverse staffing.

1.3.2 Client Rights and Family Service

The provider-agency shall have an established approach to ensure that client rights are clearly stated and communicated. Practices shall include maintaining written policies and procedures, as well as providing materials to families at the onset of care and periodically, when necessary. These shall include but are not limited to:

1) Families must be informed of the CAITS benefit description and their expected duration of care, including when their benefit will end. The provider-agency shall have an established approach to ensure that this communication is maintained throughout the course of care.

2) Families must be informed of their rights as a client and be provided with a program description, which includes the expectations for their participation in treatment, treatment plan development, treatment modifications, and problem-resolution processes prior to the establishment and implementation of services.

3) The provider-agency shall have established policies, procedures and related records to ensure focus on customer service, solicitation of family input, documentation of and response to complaints, and prompt complaint resolution. This means being able to address complaints from parents or recipients of CAITS, as well as staff working for the agency.

4) Provider-agencies shall also have written protocols as to how changes in service hours occasioned by changes in staffing will be communicated to families. Each CAITS agency must assure that services are maintained despite any planned or unplanned staffing interruptions.

5) The provider-agency must have written policies to facilitate an orderly transition of care, and/or follow-up or referral for services.

6) Written materials shall also be provided to families identifying the circumstances under which a Treatment Plan will be discontinued.

1.3.3 Unplanned Termination of Care

Each provider-agency shall identify situations that may result in the unplanned termination of services. In the case of an unplanned termination of care, the provider agency must make reasonable and documented efforts to communicate verbally and in writing to the family the reasons for termination from CAITS and wherever possible, offer alternative recommendations and resources.

1.3.3.1 Unplanned Termination of Care – No Presenting Safety Concerns

In instances where the ability to deliver services becomes compromised, the provider agency must demonstrate compliance with the following DHS requirements:

1) The provider-agency must set forth its policies and procedures in writing regarding termination of services.

2) When attempts to satisfactorily resolve disputes between the family and the provider-agency have failed, written notification shall be sent to the child's family or guardian, and DHS seventy-two (72) business hours prior to discontinuing CAITS.

3) Reasons for discontinuing treatment must be stated.

4) Alternative resources and/or referrals, if appropriate, must be given.

1.3.3.2 Unplanned Termination of Care – Presenting Safety Concerns

The development of serious safety concerns can mean the immediate suspension or termination of care. The provider-agency shall have in place written policies and procedures for dealing with risks and safety to the well being of the child/family and/or CAITS staff including:

1) The provider-agency must conform to all aspects of State mandated reporting of suspected child abuse and/or neglect.

2) The provider-agency must ensure that the child receives an emergency evaluation when indicated.

3) The provider-agency may need to seek intervention from the local police department if a situation warrants such action.

4) The provider-agency must provide immediate notification to the family, DHS, and other key collateral contacts when care becomes suspended or terminated. A record of written documentation must be maintained that describes safety concerns and directives to staff and family that result in suspension or termination of care.

1.3.3.3 Termination of Care – Parent Initiated

A parent or guardian has the right to terminate CAITS at any time. It is expected, however, that the provider-agency will make every effort to satisfactorily respond to any and all reasons that may contribute to a parent or guardian's request to end care. It is also expected that the provider-agency will assist the parent or guardian by referring to other resources for assistance.

1.4 Ethical Standards of Practice

Clearly articulated Principles of Ethical Care and Professional Conduct must be publicly posted. Protocols will identify standards of ethical practice for staff. The latter shall include, but will not be limited to, the following issues:

1) Crisis intervention and management of emergency situations (i.e., family or staff)
2) Client and professional boundaries
3) Grievance policies and procedures
4) Agencies should have policies and guidelines for use of behavior management techniques, including emergency use of restraint procedures
5) Written description of services provided

2.0 Target Population

CAITS will be available to children who are Medicaid eligible until their twenty-first (age 21) birthday if they meet the criteria for serious emotional and/or behavioral health disorder (SED) as defined in RIGL 42-72-5 (b)(24)(v), DMS-IV criteria, and the CAITS Admission Criteria. Children from birth to age three (3) presenting with serious behavioral health needs are a specialized population that may be best served in programs that specifically target this population, in collaboration with the child's RIte Care Health Plan. CAITS referrals can come from anyone involved with the child's life (i.e., self, family, school, PCP, social service agencies, hospital, mental health providers, RIte Care health plans, DCYF, etc.).

2.1 Admission Criteria

All of the following admission criteria must be met for participation in CAITS:

1) The child has a DSM-IV diagnosis as determined by an independently licensed (IL) practitioner of the healing arts with a primary presentation of moderate to severe emotional/behavioral disturbance which has led to significant impairment in functioning across daily activities and that has lasted or is expected to last at least one year and is likely to worsen without intervention; and which places the child at risk for hospitalization and/or residential treatment.

2) The child's score is 50 or below on the *Children's Global Assessment Functioning Scale* (CGAS).

3) The child is in crisis (i.e., serious disruptions in the child's normal level of daily functioning precipitated by exacerbations of their behavioral health condition, problems related to medication, or environmental stresses) and/or may be transitioning from inpatient, residential treatment, crisis stabilization, or partial hospitalization program.

4) The child can be kept safe within available community settings with supervision available from environmental supports with clinical intervention, parent training, and clinical support.

5) The child's at risk behavior is expected to improve or continue to improve with CAITS.

6) Standard outpatient treatment has not been effective and/or the child's current clinical condition has a level of risk that warrants this higher level of service intensity.

7) The child currently has no other therapeutic behavioral health home-based service (i.e., HBTS) in place. Non-therapeutic supports (e.g., Kids Connect, PASS, or Respite) may continue during a course of CAITS, but requires CAITS to coordinate with providers of non-therapeutic supports to ensure that services are not duplicated.

8) The child, family, and caregivers agree to participate in and be present for treatment when clinically indicated and appropriate.

2.1.1 Continued Stay Criteria

All of the following criteria must be met for continued participation in CAITS:

1) The child continues to meet admission criteria and a higher or less intense level of care is not appropriate due to the child's clinical presentation and needs.

2) The child continues to require a level of service intensity as defined by the CAITS guidelines.

3) Treatment is still necessary to reduce symptoms and improve functioning so that the child may be treated at a less restrictive level of care.

4) The child's progress is monitored regularly (at least weekly) and the treatment plan modified if the child is not making substantial progress towards a set of clearly defined and measurable goals.

5) There is evidence that medication trials have been initiated, ruled out, or postponed until proven effective psychosocial approaches have been implemented successfully and evaluated for sustainable outcomes.

6) The child, family, and caregivers continue to participate in and are present for treatment as clinically indicated.

7) Coordination of care and discharge planning are ongoing with the goal of transitioning the child to a less intense level of care.

2.1.2 Discharge Criteria

Any one of the following:

1) The goals established in the CAITS Treatment Plan have been met.

2) The child no longer meets admission criteria or meets criteria for a higher or lower level of care.

3) The child, family, or caregiver withdraws consent for treatment.

4) The child, family, or caregiver is not participating in treatments, is not making progress towards goals, nor is there any expectation of progress.

5) The annual CAITS benefit has been exhausted.

6) The child has lost Medicaid eligibility (See Appendix 2).

2.2 Management of CAITS Clinical Services

The CAITS provider-agency must demonstrate a sound organizational approach to ensuring the provision of effective, timely and high quality services. The CAITS team must be systematically organized with a clear delineation of staff roles, reporting relationships, and supervision.

CAITS is comprised of specialized clinical and family training and support services, including clinical assessment and psychotherapeutic interventions provided by a clinical team. The team consists of: independently licensed behavioral health clinicians licensed by the Rhode Island Department of Health (e.g., psychologist, social worker, marriage and family therapist, or mental health counselor) as well as a Master's level marriage and family therapist (MFT), mental health counselor (MHC), and social worker (MSW, LCSW) under the supervision of an independently licensed clinician. The CAITS team also includes the Family Training and Support Worker.

CAITS Certification Standards do not require providers to deliver 24/7 crisis intervention services. However, the provider-agency must have established policies for addressing after-hours crisis intervention for children and youth receiving CAITS.

2.2.1 Multiple Family Members Receiving CAITS

It is the responsibility of the CAITS provider to identify all family members receiving CAITS at any one time. The provider must develop family treatment goals and objectives in a comprehensive and clear manner for each child or youth receiving CAITS. The organization of services must be integrated and designed to stabilize and improve functioning and with an emphasis on providing a quality cost effective family treatment plan. Unless contraindicated, only one CAITS clinical supervisor, clinical treatment provider, and Family Training and Support Worker should be practicing across all children in household.

2.3 Provider Responsibilities

2.3.1 Scope of Service

CAITS providers are expected to offer rapid access to a CAITS assessment within three (3) business days or sooner from time of referral. The delivery of treatment shall commence within five business days of receiving written authorization from DHS. Provider-agencies must be prepared to deliver varying levels of clinical service intensity to meet the unique needs of children and their families. Where this service may be used to assist a child/adolescent with transition from psychiatric inpatient stay or to prevent an admission to a psychiatric hospital or residential treatment facility, the CAITS network must be prepared to meet the time-sensitive access needs reflective of a child/adolescent with acute emotional and behavioral disturbance.

Given the significant and complex clinical needs represented by the children and families served by CAITS, CAITS providers must also be able to provide intensive weekly clinical treatment which may require multiple treatment modes and frequent service delivery over the course of the initial phase of treatment. Where it is expected that the frequency and duration of weekly clinical treatment may wax and wane over the course of a CAITS episode of care, the typical pattern should reflect a higher number of clinical treatment hours in the initial phase of treatment with a slight reduction during the second phase followed by a significantly reduced need for clinical treatment hours as the child/family transition to less intensive services. Each child or adolescent's case should be assessed on an ongoing basis for the frequency and extent of units of care to meet the client and family need that often reflects varying patterns of service intensity. In each case, the provider has flexibility to determine the exact pattern of service delivery of the course of treatment.

2.3.2 Provider Staffing Requirements

2.3.2.1 Independently Licensed (IL) Clinician

1) Is responsible for providing the clinical assessment and participating in the development of the treatment plan for each child served in CAITS;

2) Is responsible for written approval of treatment plan, maintaining clinical oversight, approving subsequent treatment plan changes, and implementation of the treatment plan;

3) Is responsible for ensuring the integrity of the treatment plan regarding: identified goals and treatment objectives, intensity of treatment hours, type of interventions, and delivery of care during the period of authorized treatment;

4) Is responsible for rendering the on-going direct clinical treatment to a child and family; **or**

5) Is responsible for the clinical supervision and oversight of the on-going clinical treatment when a Master level therapist is delivering that portion of care;

6) In addition to licensure, DHS requires that individuals engaged in providing clinical supervision demonstrate competency to work with populations served by CAITS (See Appendix 3).

2.3.2.2 Masters Level Therapist

1) Is responsible for rendering the on-going direct clinical treatment to a child and family under the supervision and direction of the ILC;

2) Is responsible for participation in treatment services that focus on the stabilization of emotional disturbance, reduction of problematic behavior(s), increasing the coping skills used by child/family, and the transition to less intensive outpatient services; and

3) Is responsible for providing supervision to the Family Training and Support Worker (FTSW) in their reinforcement of treatment plan objectives.

2.3.2.3 Family Training and Support Worker (FTSW)

1) Under the supervision and direction of the treating clinician, the FTSW will assist the treating clinician in reducing the child and family's life skill deficits.

2) The FTSW, under the supervision and direction of the treatment clinician, is responsible for educating and informing the family about services and supports that may be available from the child's RIte Care health plan, community providers, school departments, CEDARR Family Support Centers and other health, social service and support agencies.

3) The FTSW can assist in the active and ongoing communication and collaboration with all parties involved in the care of this child and family as they relate to the goals and objectives outlined in the child's CAITS treatment plan.

4) The FTSW is responsible for assisting in the access to medically necessary aftercare clinical services and ensuring that possible barriers to accessing these services are

addressed. The FTSW will work closely with the child's RIte Care health plan to ensure children and families will have a seamless transition to needed services upon completion of CAITS.

2.4 Clinical Supervision Requirements

DHS requires that each CAITS provider adhere to the following policy for non-administrative clinical supervision.

2.4.1 Qualifications of Clinical Supervisor

The development of Clinical Supervisor requirements is based upon a review of DOH regulations, NASW guidelines, and other states' regulatory bodies for professional licensure and oversight of non-licensed clinical staff. An approved Clinical Supervisor shall meet the following requirements:

1) The supervisor must possess a master's degree or doctorate from an accredited program.

2) The supervisor must hold an independent license at the clinical level in the state of practice.

3) The supervisor must have no active sanction by a disciplinary proceeding.

4) The supervisor must have successfully completed one graduate course in supervision in counseling, taken at an institution of higher learning, or is certified as a supervisor within his/her own discipline, or has at least two (2) years experience supervising professional staff in a clinical mental health setting. Although provider-agencies are expected going forward to meet this requirement, DHS recognizes that some individuals already acting in this capacity may not meet this requirement. DHS will consider exceptions to this requirement on a case-by-case basis for the individuals serving in this capacity prior to August 1, 2008.

5) The supervisor must have experience and expertise in the supervisee's work setting and the patient population served.

6) The supervisor must be familiar with the administrative and organizational policies of the workplace setting of the supervisee.

7) The supervisor must be familiar with the community resources available to the supervisee for appropriate referrals of patients.

2.4.2 Supervision Requirements

All Masters Level Therapists providing treatment to children and families in CAITS must have regular one-to-one clinical supervision provided by an Independently Licensed Clinical Supervisor with the required qualifications (see Section 2.4.1). All supervision must be documented in the medical record and kept on file.

Rhode Island Department of Health[1] regulations for non-independently licensed clinicians (i.e., MHC, MFT, and MSW/LCSW) require supervised clinical casework. **CAITS providers must comply with all regulations and protocols set forth by the Rhode Island Department of Health for the supervision of non-independently licensed clinicians.**

2.5 Staff Training

It is the responsibility of the CAITS provider-agency to ensure that all CAITS staff are provided with general agency orientation and be fully informed about policies, procedures, administrative and clinical structure, training and other relevant information. Providers of CAITS are also required to ensure that staff attends scheduled trainings and workshops specifically designed for enhancing staff understanding and competencies regarding best practices in treatment and care of children and youth with serious emotional disturbances and their families. The provider-agency shall demonstrate its required basic training for all CAITS workers. This basic training shall have a core curriculum that is skills based and offered four times annually and should be tailored to the developmental training needs of the staff and team. Training may include, but is not limited to, such topics as:

- Orientation to the purpose and structure of CAITS
- Family centered practices
- Cultural Competency
- Ethical Standards, Boundaries, and Conflicts of Interest
- Mandated Reporting of Child Abuse and Neglect
- Use of physical restraint
- Emergency measures including first aid
- DOH regulations prohibiting the administration of medication by non-medical CAITS workers
- Crisis intervention and conflict resolution
- Domestic violence
- Children's mental health
- DSM-IV multi-axial structure
- Children's Global Assessment Scale (CGAS)
- Brief treatment strategies for child and family work
- Evidence based models of intervention with complex children and families
- Working with substance abusing youth/parents
- RIte Care and RIte Share Coordination
- Comprehensive Evaluation Diagnosis Assessment Referral Re-evaluation (CEDARR) Family Centers
- FCCP (Family Care Community Partnership Program)
- LEA (Local Education Authority)

[1] Department of Health; Rules and Regulations for Licensing: Mental Health Counselors and Marriage and Family Therapist [R5-63.2-MHC/MFT]; Clinical Social Workers and Independent Clinical Social Workers [R5-39.1-CSW/ICSW]

- Early Intervention

2.6 Case Load Recommendations

With a continued emphasis on safety and quality, DHS has conducted a review of case load requirements outlined by experts in the field of well established and recognized Evidence Based Programs to determine best practices for children and families. These Evidence Based Programs (i.e., Functional Family Therapy, Multidimensional Family Therapy, and Multisystemic Therapy) all promote similar caseload ranges. The afore-mentioned programs promote caseload limits and identify their caseload range as a key component in the delivery of a quality service and the promotion of quality outcomes. In an effort to establish a caseload standard that reflects the expertise of leaders in the field of behavioral healthcare, DHS is suggesting that CAITS providers consider the following caseload guidelines:

1) DHS recommends that each full-time equivalent CAITS therapist's caseload should not exceed ten (10) families.

2) DHS recommends that each full-time equivalent clinical supervisor should not supervise more than four (4) full time equivalent therapists. This would limit a full-time clinical supervisor's oversight responsibility to a 40 case maximum. In the case of part-time staff, these requirements shall be pro-rated accordingly.

2.7 CAITS Clinical Assessment

The clinical assessment must be done by a CAITS Independently Licensed (IL) clinician to determine clinical appropriateness for care. The IL also provides and/or oversees the subsequent development of that child's treatment plan and assumes signature responsibility. This clinical assessment is a face-to-face assessment of both the child and the family and should be done within three (3) business days following the referral to CAITS (See Appendix 4). The provider must make all reasonable efforts to comply with this requirement and document instances when this is not achieved citing outreach efforts.

1) All CAITS assessments shall include but are not limited to the following elements:
   - A review of the presenting problem(s) including current precipitant(s)
   - Family/caregiver's ability to understand the child/youth's strengths and weaknesses
   - Formulation of the key factors that contribute to and maintain targeted behaviors as well as an identification of the changes needed to alleviate them (including difficulties/obstacles to improvement) in order to enable achievement of treatment goals
   - Risk factors and level of risk to harm self/others
   - Child and family stressors
   - Relevant developmental history
   - History of substance abuse evaluations and treatment
   - Relevant background and family history
   - Family/natural supports

- Family/caregiver's ability and willingness to engage in proposed treatment
- Involvement of other past and present service providers
- Collateral contacts (e.g., school and legal system)
- History of educational assessment and services
- Mental status examination
- A DSM-IV multi-axial diagnosis/evaluation including CGAS
- Relevant medication history
- Referral for psychiatric evaluation when appropriate

2) All CAITS treatment goals shall be:

- Objective, behaviorally defined, observable and measurable, and conform to brief treatment expectations

2.8 Development of Treatment Plan

CAITS treatment must be implemented within five (5) business days of receiving CAITS authorization. The Independently Licensed clinician who performed the clinical assessment may either assume treatment of the child/family or assign the case to a Master's level therapist under the supervision of an IL clinician.

All treatment planning must involve the child/family/caregiver with an emphasis on promoting the family's identification of critical treatment needs that improves the child's functioning within a CAITS episode of care. A CAITS treatment plan must formulate the factors needed to alleviate the key variables of maladapted behaviors and the proposed treatment interventions that will enable achievement of treatment goals. Treatment plans must:

- Outline treatment intervention(s) and document the relationship between the intervention(s) and the corresponding goal(s)
- Identify treatment modalities and the frequency and duration of each modality
- Clearly define roles and responsibilities for each member of the team
- Clearly define family participation
- Actively coordinate and communicate with others providing services to the child and family, including the child's Primary Care Physician (PCP) or other involved healthcare providers, as appropriate (e.g., child psychiatrist or nurse practitioner)

2.9 Treatment

CAITS treatment must incorporate the use of defined clinical interventions that are rooted in evidence-based practices and are expected to achieve positive outcomes. All treatment interventions must be problem focused and solution oriented, well defined, and clearly relate to the documented treatment plan/goals. Interventions are both practical and tailored to the unique characteristics of the family and can be implemented to achieve attainable treatment goals. This requires the active and sustained participation of family members in defining treatment objectives and receiving care. The CAITS provider shall work with the child's RIte Care health plan to ensure that the child has timely access to and receives a psychiatric evaluation for

diagnostic clarity, treatment direction, and medication evaluation. If the child is in Medicaid Fee for Service (FFS) delivery system, the CAITS provider shall help the family access care from a child psychiatrist.

CAITS clinical services include individual and family therapy. The frequency and type of therapies being provided must be clearly supported by a child's treatment plan. Assessment of treatment progress including the modification of treatment objectives and/or interventions is ongoing throughout a course of care. When additional clinical treatment is indicated and not provided within the CAITS array of services, CAITS providers shall refer to the child's RIte Care or RIte Share health plan or State of Rhode Island Fee for Service Medicaid delivery system.

The delivery of clinical care is intended to stabilize a child or youth's presentation in a rapid and efficient manner. Providers have the flexibility to manage the utilization of approved service units by involving the child and family in receiving more intensive treatment at the outset of care. The early delivery of intensely focused treatment allows for the development of alliances, a reduction in resistance, the minimization of hopelessness, the reduction in non-compliance with care, and can greatly improve the potential for success. As treatment progresses through the mid phase of care, presenting problems have been reduced or changed such that more positive coping takes place for the child, youth, and family, thus allowing for maintenance and generalization as care moves into the later phase of treatment.

2.10 Transition and Discharge

CAITS is based upon an acute short-term model of clinical intervention. The successful transition to less intense levels of care is a major objective. Discharge planning is therefore a dynamic process involving family members and supported by the Family Training and Support Worker in conjunction with direction from the clinical supervisor and recommendations from the treatment team. Family members are expected to be fully informed about the objectives of CAITS and knowledgeable about transition and discharge planning from the start of care.

In preparation for discharge from CAITS, the clinical supervisor must define the appropriate and timely transition of care from CAITS. This may include one or more joint meetings or treatment sessions that incorporate the child/family/caregiver with the CAITS clinician and the new treatment provider (e.g., 0utpatient services, HBTS). The CAITS clinician shall work collaboratively with the child's RIte Care/RIte Share health plan to facilitate a timely and seamless transition to appropriate aftercare services.

When all attempts to stabilize fail and a child in CAITS requires transition to a higher level of care, providers are expected to facilitate the transfer of clinical information to all appropriate health care provider entities and the child's RIte Care health plan (See Appendix 5).

The provider-agency must have policies and procedures for the following situations (also described in Section 1.3):

- A parent or guardian may decline to accept treatment following a CAITS intake evaluation. The provider-agency must provide alternative recommendations and referrals in collaboration with the child/family's health plan
- Complaints from parents/recipients and staff working for the agency
- Participant's non-compliance that may result in termination of care

2.11 Early Termination of CAITS

An early discharge from CAITS occurs when care is terminated prior to completing the 16-week maximum available for the 12-month timeframe. Whenever this occurs, providers are required to submit a CAITS Notification of Early Discharge form to the CAITS Clinical Review Department within seventy-two (72) business hours (See Appendix 6). This form reports the last date of service delivery and how many total service units were provided during the authorized course of care.

2.12 Compliance with DCYF Regulations

A Bureau of Criminal Investigation (BCI) report must be obtained and background reports through the Child Abuse Neglect Tracking System (CANTS) by DCYF are required of all potential employees of CAITS. The provider-agency must have policies in place to guarantee that these screenings take place.

2.13 Data Reporting

A work group will be formed in the initial months of CAITS implementation to determine specific data elements that DHS will monitor about CAITS including clarification regarding continued participation in the Yale Study project. Refer to Appendix 7 for additional required reports.

2.14 Documentation Requirements

Providers are required to keep all records necessary to fully disclose the nature and extent of the services provided to children receiving CAITS. All CAITS must be provided in accordance with an approved comprehensive treatment plan that clearly documents the medical necessity of the services. Documentation must conform to the guidelines provided in these Certification Standards (See Appendix 8).

Providers must furnish to DHS and/or the Medicaid Fraud Control Unit of the Attorney General's Office such records and any other information regarding payments for claims or services rendered that may be requested.

3.0 Service Authorization and Reimbursement

CAITS requires prior authorization (PA) from DHS. The maximum number of units is fixed for each procedure code and should be delivered within 16 weeks or less. Although the authorization process approves a set number of units per procedure, how services are delivered is

directly determined by the treatment needs of each child. This authorization process allows providers the flexibility to utilize units as described in Sections 2.3.1 and 2.9 and as outlined in Appendix 9. Types of services are listed below:

CAITS SERVICES

Reimbursable Services	Maximum Hours
Individual/Family Therapy	40
Family Training and Support Worker Services	18
Assessment and Treatment Plan Development	N/A

Reimbursement is based on the units of service approved as part of an authorized Treatment Plan. The following rules apply:

1) CAITS is available for up to 16 weeks per 12-month period. The 12-month period begins on the first day of the approved CAITS authorization.

2) The provider-agency must submit the CAITS Clinical Treatment Request Form (CTRF) to the Clinical Review Department. The information on this form is the basis upon which the provider-agency will receive notification of authorization.

3) A maximum number of units by procedure code are entered into the PA system when CAITS is authorized. Once the maximum number of service units is exhausted, no additional units are available within the 12-month timeframe.

4) Payment of authorized services requires a participant's enrollment in Medicaid. It is the responsibility of the provider-agency to verify eligibility. Claims rendered during a period of lapsed eligibility may result in suspension or loss of payment.

It is the responsibility of the CAITS provider agency to submit notification to the Clinical Review Department should a child or youth require an inpatient psychiatric hospitalization or residential care during a course of CAITS care (See Appendix 5).

3.1 Management of Service Units

The delivery of clinical care is intended to stabilize a child or youth's at risk behaviors in a rapid and efficient manner. Providers have the flexibility to manage the utilization of approved service units by involving the child and family in receiving more intensive treatment at the onset of care. As treatment progresses through the mid phase and ending phase of care and presenting problems have been reduced or changed such that more positive coping takes place for the child, youth, and family, providers are able to adjust the service unit usage appropriately. The focus is on delivering the appropriate service intensity level in direct correlation to the child's treatment plan and subsequent treatment plan adjustments. The ability to titrate service unit usage allows the CAITS provider to reduce service delivery as the child and family transition to less intensive services and treatment and/or community resources.

3.2 Hearing and Appeal Rights

If a child's parent or guardian objects to the decision regarding eligibility for CAITS, they can request an appeal through the DHS hearing process. For further information regarding eligibility refer to Sections 1.2 and 2.1 through 2.1.2. An Administrative Fair Hearing allows for testimony to be presented from all concerned parties. In turn, the Hearing Officer renders a written decision. Rules and procedure for requesting a Fair Hearing are provided in Appendix 10.

3.3 Coordination of Benefits

In cases where there are multiple payer sources, the provider-agency must adhere to the following guidelines:

1) Medicaid is the payer of last resort.

2) All other forms of insurance coverage must be accessed prior to Medicaid (i.e., commercial coverage, Medicare, etc.)

3) The provider must submit either a copy of the third party insurer's denial letter, CFIT benefit exhaustion letter, or a TPI form with the request for payment.

4.0 Provider Certification

4.1 Certification of Existing Provider-Agencies

Existing CIS provider-agencies are eligible to become certified CAITS providers by attesting to full compliance with these CAITS Certification Standards effective August 1, 2008. These Certification Standards include certain performance standards. Certification requires that providers adhere to these standards and performance expectations, as well as provide reports to DHS (see Appendix 7) Subsequent to certification DHS will monitor the performance of certified CAITS provider-agencies and their continued compliance with certification requirements. Monitoring will consist of periodic site visits, chart audits, and reviews of agency policies and procedures. Certified providers are required to notify DHS of any material changes in their organization's circumstances or in program operations. On the basis of ongoing monitoring, including review of required reports submitted by certified provider-agencies, DHS might identify deficiencies in performance and/or compliance with certification requirements. Based on such review and related communications, certification status may be modified to Provisional Certification.

DHS requires formal notice from any existing CIS provider-agency that does not seek to become CAITS certified by August 1, 2008. The provider-agency must submit to DHS a written plan of transition for children or youth currently receiving CIS that may require CAITS. This plan shall identify referral sources and effect an orderly transition of care to the receiving CAITS provider or other treatment provider(s) including all appropriate clinical records.

4.2 Instructions and Notifications to New Applicants

These Certification Standards also serve as the application guide for new applicants seeking to become CAITS providers. This document identifies the standards against which applicants will be evaluated. Applications will be evaluated on the basis of responses to each of these specific standards and expectations. In addition to the core standards, the organizational capacity of each applicant will be evaluated as well as its ability to be HIPPA compliant and family centered throughout its design. The applicant must provide evidence that all appropriate timelines can be met. Applicants are advised that a site visit will be conducted by DHS prior to certification.

Applicants are to address each of the areas in the sequence presented herein. Prior to technical review, submitted applications will be reviewed for completeness and for compliance with core expectations. Incomplete applications will be returned without further review.

Applicants are advised that all materials submitted to the State for consideration in response to these certification standards will be considered to be Public Records as defined in Title 38 Chapter 2 of the Rhode Island General Laws, without exception.

There is no limit to the number of applicants that can seek certification. Interested parties are encouraged to contact the Center for Child and Family Health at DHS for further information and clarification. Letters of Interest are strongly encouraged to ensure that DHS is able to keep interested parties up to date regarding scheduled meetings or program clarifications that may be needed. Inquiries, Letters of Interest, requests for application, and/or completed applications should be directed to:

Sharon Kernan, RN, MPH
Center for Child and Family Health
Department of Human Services
600 New London Avenue
Cranston, RI 02920
Phone: (401) 462-3392
sharonk@dhs.ri.gov

This certification review process should be completed within thirty (30) days of the State receiving a completed Certification Application from a potential vendor. A letter will be sent to the application agency offering certification and identifying any conditions to the certification. A signed acceptance of certification is required.

An additional amount of time may be required for the State to collaboratively work with an applicant whose proposal does not meet Certification Standards, as determined by the CAITS Certification Application Review Committee. The provider-agency may then address concerns in order to proceed to certification or withdraw its application.

4.3 Possible Outcomes of Certification Review Process

Certification applications will be reviewed and scored based on the degree to which an applicant demonstrates a program that complies with the requirements set forth in these CAITS Certification Standards.

The following certification outcomes are possible as a result of the application review process. These are:

4.3.1 Certification With No Conditions

The provider-agency fully meets all certification requirements.

4.3.2 Certification With Conditions

An applicant may describe a program that meets most of the Certification Standards, but for one reason or another does not fully comply with the certification requirements at the time of application submission. In such case, the applicant may be offered "Certification with Conditions" and application deficiencies will be identified by the State. The applicant will be required to address them by submitting a corrective action plan with specific dates for addressing deficient areas of compliance. This plan must be accepted and approved by DHS.

4.3.3 Not Certified

The applicant does not meet requirements for CAITS certification. In no case will a potential vendor in the Not Certified status be allowed to provide any CAITS service or bill the Medicaid authority for any such activity. The provider-agency may reapply at anytime.

4.4 Provisional Certification and Suspension of Certification

As a result of its review activities, DHS may identify deficiencies wherein a provider-agency is not in satisfactory compliance with certification and/or performance standards. In such instances, DHS will notify the provider-agency in writing of any such deficiencies. Failure by the provider-agency to successfully address and resolve all stated deficiencies may result in the implementation of provisional rates for non-compliance (See Appendix 9). For further clarification, providers should refer to DHS Policy Manual: Section 300.40 – Procedure for Imposing Administrative Sanctions (REV: 08/2007).

4.5 Continued Compliance with Certification Standards

Certified CAITS providers shall comply with these CAITS Certification Standards throughout the period of certification. Failure of DHS to insist on strict compliance with all certification standards and performance standards shall not constitute a waiver of any of the provisions of these certification standards and shall not limit DHS' right to insist on such compliance. DHS reserves the right to monitor and evaluate provider-agencies for compliance with Medicaid and State laws, as well as these Standards and DHS regulations and policies. For purposes of review, certified and provisionally certified providers will provide access to DHS and/or its agents at reasonable times to appropriate personnel and written records. The State reserves the right to apply a range of sanctions to providers, which are out of compliance. These may include:

- Suspending new referrals.
- Change of certification status to Provisional Certification with associated rates

- Recoupment of funds when violations of Medicaid regulations, State law, or DHS policies, including these Certification Standards, have taken place
- Dependent on severity of violation, suspension of certification
- Referral to appropriate legal authorities

4.6 Oversight and Authorization

DHS may place limits on services (e.g., amount, duration, and scope of services) and exclude any service that it determines is not medically necessary, is unsafe, experimental, or is not generally recognized as an accepted method of medical practice or treatment Code of Federal Regulations (CFR): Section 440.230 and DHS Provider Manual).

5.0 Organization of Services

5.1 Health and Safety, Risk Management

The provider-agency must have protocols for the identification and management of safety risks, family crises, medical emergencies or situations that would place the worker or others at risk, and difficult situations that could compromise the well being of staff and others. Provider-agencies must have an effective incident review process.

5.2 Staffing

- Licensed Clinician: Must have an Independent License issued by the RI DOH. For those clinicians with a license from another state, it is required that licensure from RI DOH be obtained as soon as possible. Requirements for licensure reciprocity depending on one's professional discipline may vary. It is the responsibility of the provider-agency to demonstrate oversight and a plan to achieve reciprocity.

- Masters' Level Clinician: Must possess a Masters' degree in a clinically related field of behavioral health. DHS recommends that provider-agencies hire staff that can qualify for future independent licensure (e.g., LICSW, LMHC, or LMFT).

- Family Training and Support Worker: Must have a BA or higher and one year of experience with the population served. DHS recognizes that some individuals already acting in this capacity may not meet this requirement. DHS will consider exceptions to this requirement on a case-by-case basis for the individuals serving in this capacity prior to August 1, 2008

6.0 Qualified Entity

The State is seeking to allow new entities in addition to current providers of CIS to provide CAITS. A multifaceted community-based provider-agency must be able to demonstrate that it has the organizational and management structure, staffing resources, quality assurance structures and financial systems to address all aspects of the delivery of CAITS. Provider entities must be able to demonstrate that they also have a sound multidisciplinary organization that is capable of

providing high quality, consistent, and effective care that fully meets these certification standards. In accordance with Title 7, Chapter 1.1 of the General Laws of Rhode Island, no foreign corporation, a corporation without a Rhode Island business address, shall have the right to transact business in the state until it shall have procured a Certificate of Authority to do so from the Rhode Island Secretary of State.

State requirements in these areas are consistent with the types of expectations or standards, which would be set forth and surveyed by health care accrediting bodies, and which are generally held to be critical to effective, consistent, high quality organizational performance and care provision.

In some cases, an applicant may seek certification as a joint entity or represent itself as a joint partnership with another provider(s). Regardless of the form, a single legal entity will be certified having the overall responsibility for performance.

Overall, a certified CAITS provider must show that it can:

- Meet all of the standards as outlined
- Effectively manage all referrals
- Promptly deliver and maintain quality care to CAITS recipients
- Screen and Recruit qualified staff
- Evaluate, train, and retain staff
- Provide necessary clinical oversight for non-licensed or Masters level clinical staff
- Consistently verify Medicaid eligibility of recipients
- Reliably submit claims for services rendered
- Adhere to Medicaid and State regulations/laws

Appendix 1: Definition of Medical Necessity

As defined and applied to all State Medicaid programs (See RI DHS Medical Assistance Program, 300-40-3, September 1997), *Medical Necessity* refers to medical, surgical, or other services required for the prevention, diagnosis, cure or treatment of a health related condition. It includes services necessary to prevent a decremental change in either medical or mental health status. Services must be provided in the most cost-effective, efficient and appropriate manner. Services are not to be provided solely for the convenience of the beneficiary or service provider.

The prescription or recommendation of a physician or other service provider of medical services is required for a determination of medical necessity to be made, but such prescription or recommendation does not mean that the Medical Assistance Program will determine the provider's recommendation to be medically necessary. The Medical Assistance Program is the final arbiter of determination of medical necessity (See RI DHS Medical Assistance Program, 300-40-4, September, 1997).

Appendix 2: Provider-Agency Responsibility for Monitoring Medicaid Eligibility

A recipient's eligibility to receive Medicaid can change at any time. It is the responsibility of the CAITS provider to verify eligibility. This can be accomplished by contacting the Recipient Eligibility Verification System (REVS) at 784-8100 or the DHS website (www.dhs.ri.gov).

Loss of Medicaid coverage results in nonpayment of claims. Providers may request retroactive reimbursement from EDS once Medicaid coverage has resumed if the child is retroactively reinstated providing:

- The child has Medicaid eligibility during the dates of service authorized
- The child has had an approved CAITS Treatment Plan

Appendix 3: Professional Standards

1.1 Licensure

These Certification Standards require that the individuals engaged in providing Clinical Supervision and those performing the CAITS assessment hold a valid license from the Rhode Island Department of Health (DOH). DOH stipulates that licensure is required for health care professionals if:

a) You represent yourself in name, title, or abbreviation to the public as a psychologist, clinical social worker, marriage and family therapist, and mental health counselor; or if

b) You engage in providing diagnosis, assessment, treatment planning, and treatment to the public.

1.2 Competence

Licensure relates to broad areas of clinical practice and by itself does not ensure that clinicians have the specific and current competencies to work effectively with the population of children/youth/families receiving CAITS. Specific evidence of the following is required:

a) Training: 2 years of post degree clinical supervision while working with the target population; and

b) Education: Ongoing continued professional development as evidenced by satisfactorily meeting DOH requirements for one's respective licensing Board. Provider-agencies are responsible for oversight and management of this requirement.

For non-independently licensed clinical staff, the provider-agency must demonstrate that it can monitor and enforce the following:

a) Clinical Supervision:

All non-independently licensed clinical staff shall be supervised by the IL clinician assigned to a child or youth's Treatment Plan on a consistent and scheduled basis.

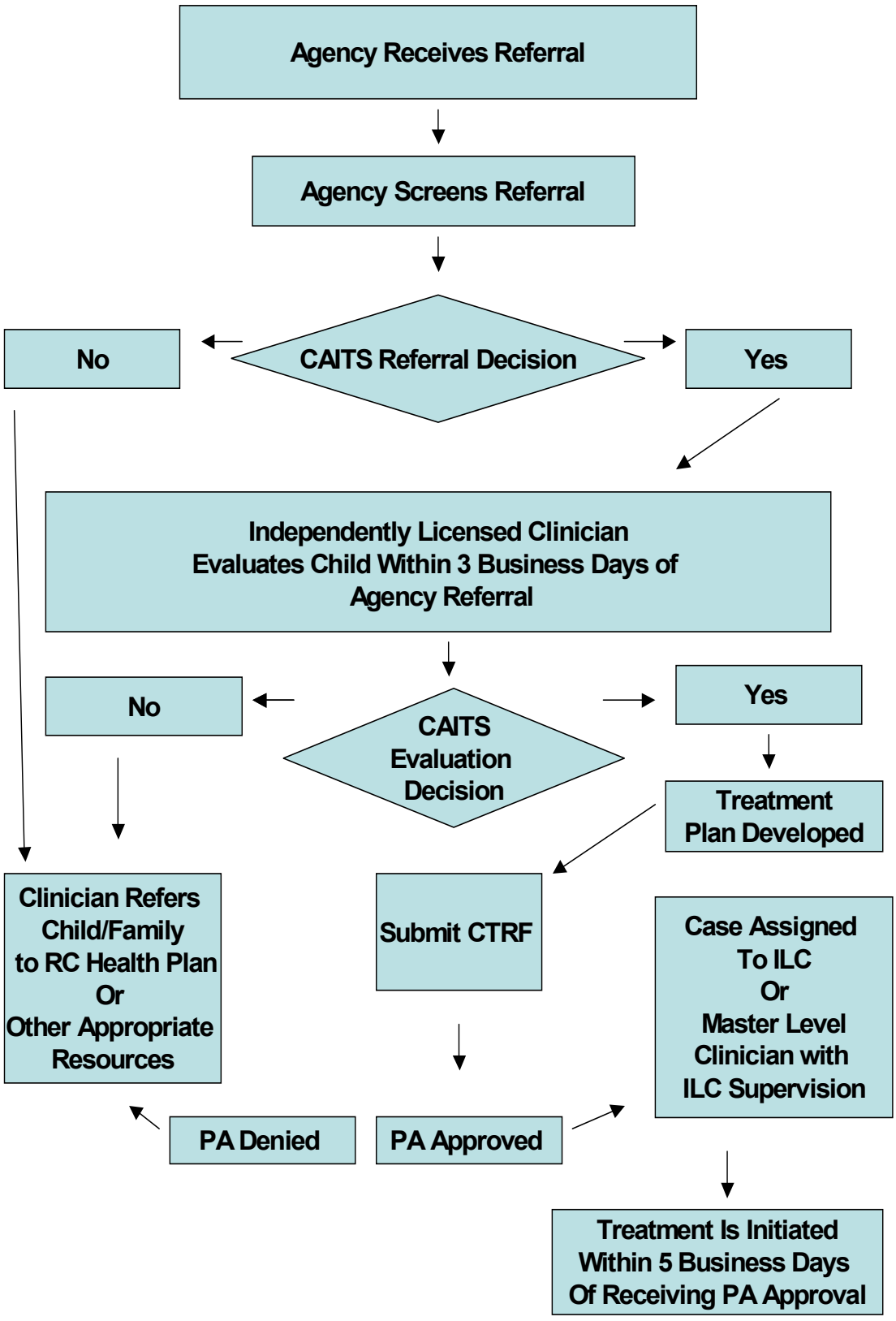
b) Preparation for Independent Licensure:

It is the responsibility of the provider-agency to inform DHS of the licensure status of all clinical staff. Each area of professional practice has its own post degree supervision and clinical work requirements to be eligible to sit for licensure examination. It is recommended that the provider-agency facilitate a plan of licensure preparation at the time of hiring that supports the non-independently licensed clinician in obtaining independent licensure. This plan should conform to DOH expectations (including CME requirements) and be reviewed every 12 months.

1.3 Training of Non-licensed Bachelor's Level Staff:

Agencies shall determine in-service trainings for Bachelor level staff (See Section 2.5 for additional information).

Appendix 4: AGENCY PROCESS FLOW



Appendix 5: CAITS Notification of Admission to Higher Level of Care

Identifying Information:

Last/First Name: _____ DOB:_____ MID#:_____

CAITS Agency: _____ Provider#: _____ Phone #: _____

CAITS Contact Name: _____ Phone #:_____ Fax #: _____

Child's Health Plan Coverage: NHPRI BCBS UHC MA (Fee-For- Service) Other: _____

CAITS Start Date: _____CAITS End Date (last date of actual service delivery):_____

Please identify which level of care the child was admitted to:

- ❑ **Psychiatric Hospital**
- ❑ **Medical Hospital**
- ❑ **Partial Psychiatric Hospital**
- ❑ **Acute Residential Treatment (ARTS)**
- ❑ **Residential Treatment**
- ❑ **Group Home**
- ❑ **Other:**_____

Date of admission: _____

Anticipated date of discharge: _____

Reason(s) for admission: _____

The CAITS provider must report the exact number of billable service units delivered from the first through the last date of service within this authorized period of CAITS:

- H0004 (Behavioral Counseling and Therapy): ____ units
- H2014 (Skills Training and Development): _____units

IL Clinical Supervisor: _____ Clinician: _____

Appendix 6: CAITS Notification of Early Discharge

Identifying Information:

Last/First Name: _____ DOB: _____ MID#:_____

CAITS Agency: _____ Provider#: _____ Phone #:_____

CAITS Contact Name: _____ Phone #:_____ Fax #: _____

Child's Health Plan Coverage: (Circle all that apply) NHPRI BCBS UHC Other: _____

CAITS Start Date: _____ CAITS End Date (last date of actual service delivery):_____

Reason for Discharge:

- ☐ Goals Met
- ☐ Child in need of higher level of care
- ☐ Child/Family Refused CAITS
- ☐ Reached 21 years of age
- ☐ Parent(s) Requesting Discharge
- ☐ Non-Compliance With Treatment
- ☐ Transfer to New Provider
- ☐ Change in Custody Status
- ☐ Other _____

Discharge Diagnosis: _____ CGAS: _____
Discharge To: _____

Other Agency Involvement/Contacts: (IE. DCYF; CEDARR; LEA; Other)

_____

_____

Have they been notified? Yes ___ No ___ Date: _____
IL Clinical Supervisor: _____ Date: _____

The CAITS provider must report the exact number of billable service units delivered from the first through the last date of service within this authorized period of CAITS:

- H0004 (Behavioral Counseling and Therapy): ____ units
- H2014 (Skills Training and Development): _____units

Appendix 7: CAITS Data Requirements

A work group will be formed in the initial months of CAITS implementation to determine specific data elements that DHS will monitor about CAITS including clarification regarding continued participation in the Yale Study project.

The following reports are required to be sent to DHS:

- Submission of staff credentials and copies of DOH licenses once per year
- Submit reports of all grievances and complaints received, along with agency findings and responses, and logs of timeliness of complaint resolution on an annual basis (i.e., by July 31st annually)
- Submit reports of all incident reports received during provision of CAITS (i.e., health and safety issues, allegation of abuse, and accidents) along with agency findings and responses on an annual basis (i.e., by July 31st annually)

Appendix 8: CAITS Documentation Requirements

Providers must ensure that their documentation is consistent with the requirements outlined in Section 1.0 and 2.0 of the CAITS Standards.

1.0 Documentation Requirements

The following are the basic principles of documentation:

1) The service/client record should be complete and legible

2) The documentation of each client/consumer encounter should include or provide reference to:

   a) The reason for the encounter, and as appropriate, relevant history

   b) Current clinical status

   c) Written treatment or progress notes including care provided and the setting in which the services were rendered

   d) Date and time and legible identity/credentials of care provider

   e) The amount of time it took to deliver the services

3) The client's progress, response to and changes in treatment and any revision of the Treatment Plan should be documented.

4) A clear trail must be maintained. Each provider is responsible for devising a system that documents services, which have been provided. This back-up information is usually contained in the client record, daily log, or both and must be sufficiently detailed to show that a client received a specific number of hours of treatment services and that a corresponding number of hours were billed to Medicaid.

2.0 Methods of Documentation

1) The client's progress and current status in meeting the goals and objectives of his or her Treatment Plan must be regularly recorded in the client record in the form of progress notes. Progress notes must include:

   a) Documentation of the implementation of the Treatment Plan

   b) Chronological documentation of the client's clinical course

c) Significant events and/or changes in the client's condition should be documented with a full narrative note whenever they occur

d) Periodic documentation of all treatment provided to the client

e) Descriptions of the response of the client to treatment as well as the outcome of treatment

3) A discharge summary must be entered into the client record within a reasonable period of time after discharge. The Discharge Summary must include:

a) Significant findings including final primary and secondary diagnoses

b) General observations about the client's condition initially, during treatment and at discharge

c) Whether the discharge was planned or unplanned and, if unplanned, the circumstances

d) Assessment of attainment of the Treatment Plan objectives

e) Documentation of referral to other appropriate program or agency

3.0 Monitoring and Quality Assurance

Site visits will be conducted by DHS staff to monitor appropriate use of Medicaid services and compliance with the procedures outlined in this manual. During these visits, staff will review the following:

1) Client records and Treatment Plans
2) Staff orientation programs and attendance logs
3) Agency policy and procedures related to CAITS service provision
4) Claims information/documentation
5) Staff time sheets
6) Complaint log

Providers will be notified of DHS site visits in advance. Unannounced site visits may also be conducted at the discretion of the Department. DHS staff may contact or visit families as part of the oversight and monitoring activities.

In the event of adverse findings of a minor nature, repayment to DHS may be required. In situations where, in the opinion of the Department, significant irregularities in billing or utilization are revealed, providers may be required to do a complete self-audit in addition to making repayments. In addition to monitoring conducted by DHS, providers are subject to periodic fiscal and program audits by CMS.

4.0 Client Record Guidelines

All CAITS must be provided in accordance with a comprehensive Treatment Plan that documents the medical necessity of the services. Treatment Plans must conform to the following guidelines:

1) Each client shall have a current written, comprehensive, individualized Treatment Plan that is based on assessments of the client's behavioral health needs

2) Responsibility for the overall development and implementation of the Treatment Plan must be assigned to an appropriate member of the professional staff

3) The Treatment Plan must be reviewed at major decision points in each client's course of treatment including:

   a) The time of admission and discharge
   b) A major change in the client's condition
   c) The point of the estimated length of treatment
   d) Modifications to treatment

4) The Treatment Plan must contain specific goals that the client must achieve and/or maintain as well as maximum growth and adaptive capabilities. These goals must be based on periodic assessments of the client and as appropriate, the client's family.

5.0 Supplemental Guidelines:

1) Medicaid is, by definition, a *medical* program, which pays for *medical* services. A Treatment Plan is regarded as a prescription for services and must be signed by an appropriate professional, in this case, an Independently Licensed Practitioner of the Healing Arts.

2) The diagnosis must clearly be evident in the Treatment Plan and the diagnosis must be considered as the overall plan is developed. There must be a clear connection between the diagnosis and the symptoms of the condition for which the client is being referred.

3) The reasons for, and the amount and duration of each specific intervention should be evident in the plan.

4) Progress notes should reflect a judgment being made by the provider regarding the results of the treatment rendered, i.e., an assessment of why the interventions prescribed are/are not working. The notes should also show that the writer is aware of why things were done rather than merely what was done.

Appendix 9: Service Units, Procedural Codes, and Reimbursement Rates

Certified Provider Rates

Procedure	Code	Rate/Hour	Units	Hours
Behavioral Counseling & Therapy	H0004	$98.00	160	40
Skills Training & Development	H2014	$88.00	72	18
Treatment Plan Development	T1023	$300.00	1	

Unit of Service = 15 minutes for codes H0004 and H2014

Provisional Provider Rates

Procedure	Code	Rate/Hour	Units	Hours
Behavioral Counseling & Therapy	H0004	$88.00	160	40
Skills Training & Development	H2014	$79.00	72	18
Treatment Plan Development	T1023	$270.00	1	

Unit of Service = 15 minutes for codes H0004 and H2014

Procedure codes for CAITS were taken from the *Healthcare Common Procedure Coding System (HCPCS) 2006.*

Appendix 10: Appeal Rights
Rhode Island Department of Human Services

APPEAL RIGHTS – READ CAREFULLY

You have a right to discuss this action further with my supervisor, or me or to request an adjustment conference with the appropriate DHS Supervisor. **If you have questions regarding this notice, call the Agency representative at the telephone number listed on the first page of the notice.**

You have the right to request and receive a hearing if you disagree with the decision made regarding the level or length of services, in the approved treatment plan. You must request a hearing in writing within thirty (30) days of this notice.

If you request a hearing regarding your medical services within ten (10) days of this notice, you will continue to receive the current amount of Medical Assistance Services until a hearing decision is made.

The form to request a hearing is enclosed. If you request a hearing you may represent yourself or authorize another person, such as a relative or legal counsel to represent you. Free legal help may be available by calling Rhode Island Legal Services at 274-2652 (outside the Providence calling area, call toll free at 1-800-662-5034).

EXCEPTION: If this action implements a hearing decision, you may not have the right to another hearing on this action. See the hearing decision letter for your right for judicial review in accordance with Rhode Island law (42-35-1 et seq.).

TO REQUEST A HEARING

All requests must be in writing. To request a hearing, complete Section I., the 'Statement of Complaint' on the REQUEST FOR A HEARING form or else submits your complaint in writing. Briefly describe the Agency action you wish to appeal. You can fill out the form yourself, or with the help of the Agency representative if you need help in completing the form. The form is signed by the person to whom the notice is addressed or her/his representative.

Mail or bring the hearing request form to the Center for Child and Family Health, Department of Human Service's Forand Building, 600 New London Avenue, Cranston, RI 02920. In order to

receive a hearing, you must do so within the time periods specified on this page. You will be notified of the time and place of the hearing. At the same time, you will also receive a statement of the Agency's position, an explanation of the policy on which the decision was based, and additional information about the hearing process.

INFORMATION ABOUT HEARINGS FOR APPLICANTS AND RECIPIENTS OF FINANCIAL ASSISTANCE, FOOD STAMPS, MEDICAL ASSISTANCE AND SOCIAL SERVICES

The Department of Human Services (DHS) has a responsibility to provide financial assistance, food stamps, medical assistance, and social services to individuals and families for whom eligibility is determined under the provisions of the Social Security Act, the Rhode Island Public Assistance Act, the Food Stamp Act, the Rhode Island Medical Assistance Act and Title XCX Social Services.

The hearing process is intended to insure and protect your right to assistance and your right to have staff decisions reviewed when you are dissatisfied. You have asked for a hearing because of an agency decision with which you disagree. The following information is sent to help you prepare for your hearing and to inform you about what you may expect and what will be expected of you when it is held.

1. WHAT IS A HEARING?

A hearing is an opportunity provided by the Department of Human Services to applicants or recipients who are dissatisfied with a decision of the agency, or a delay in such a decision for a review before an impartial appeals officer to insure correct application of the law and agency administrative policies and standards**.**

2. WHO CONDUCTS A **HEARING?**

A hearing is conducted by an impartial appeals officer appointed by the Director of the Department of Human Services to review the issue(s) and give a binding decision in the name of the Department of Human Services.

3. **WHO MAY ATTEND** A **HEARING?**

A hearing is attended only by persons who are directly concerned with the issue(s) involved. You may be represented by legal counsel if you choose and another witness or a relative or friend who can speak on your behalf. The Agency is usually represented by the staff member involved in the decision and/or that worker's supervisor. Legal services may be available to persons wishing to be represented by legal counsel through Rhode Island Legal Services (274-2652) or (1-800-662-0534).

If an individual chooses to have legal representation, e.g. be represented by an attorney, paralegal, or legal assistant, the representative must file a written Entry of Appearance with the Hearing Office at or before the hearing. The Entry of Appearance acts as a release of confidential information, allowing the legal representative access to the agency case record. It is also needed for the Hearing Office to confirm the representation for purposes of follow-up, review, request for continuances, etc.

4. WHERE IS THE HEARING HELD?

The hearing may be held at a regional or district office or in an individual's home when circumstances require.

5. HOW CAN YOU LEARN ABOUT THE DEPARTMENT'S RULES AND REGULATIONS?

Section III of DHS-121 form shows the policy manual references, which are at issue in your hearing. You may review the Department's regulations at any local welfare office during regular business hours.

You may also review the Department's hearing decisions rendered on or after April 1987. They are available only at the DHS Central Administration Building, 600 New London Avenue, Cranston Rhode Island, between the hours of 9:00 a.m. and 11:00 a.m. and between the hours of 1:00 p.m. and 3:00 p.m. Monday through Friday.

6. WHAT ARE YOUR RIGHTS RELATIVE TO THE HEARING?

You have a right to examine all documents and records to be used at the hearing at a reasonable time before the date of the hearing, as well as during the hearing.

You may present your case in any way you wish without undue interference, by explaining the situation yourself or by having a friend, relative, or legal counsel speak for you, and you may bring witnesses and submit evidence as discussed above to support your case. You will have an opportunity to question or refute any testimony or evidence and to confront and cross-examine adverse witnesses.

7. HOW IS A HEARING CONDUCTED?

A hearing differs from a formal court procedure because you are not on trial and the appeals officer is not a judge in the courtroom sense. However, any person who testifies will be sworn in by the appeals officer.

After you have presented your case, the staff member will explain the provisions in law or agency policy under which s/he acted. When both sides have been heard, there will be open discussion under the leadership and guidance of the appeals officer. The entire hearing is recorded on tape.

8. HOW WILL THE HEARING DECISION BE MADE?

The tape recording of the testimony of the persons who participated in the hearing, together with all papers and documents introduced at the hearing, will be the basis for the decision.

The appeals process is generally completed within 30 days of the receipt of your request, but will never exceed sixty (60) days for food stamps and ninety (90) days for all other programs unless you request a delay, in writing, to prepare your case.

The appeals officer will inform you of her/his findings, in writing, following the hearing. If you are still dissatisfied, you have a right to judicial review of your case. The agency staff member wants to be as helpful as possible in assisting you to prepare for the hearing. If you have any questions about what you may expect, or what may be expected of you, be assured that you may call your eligibility technician or worker.

RHODE ISLAND DEPARTMENT OF HUMAN SERVICES **DHS-121**
REQUEST FOR A HEARING **REV. 01/90**

SECTION I - IDENTIFYING INFORMATION

NAME _____
Recipient Category Case Number/Social Security Number

ADDRESS _____
Number and Street City/Town ZIP

SECTION II - STATEMENT OF COMPLAINT (To be completed by applicant or recipient).

_____

_____

_____

_____

_____

☐ I wish to continue to receive the amount of assistance and/or food stamps I now receive until the hearing decision

☐ I do not wish to continue to receive the amount of assistance and/or food stamps I now receive until the hearing decision

If the hearing decision is not in my favor, I understand that I must repay any assistance and/or food stamps for which I am determined ineligible.

Signature _____ Date _____
(Recipient)

SECTION III - STATEMENT OF AGENCY POLICY (to be completed by the agency representative)

Date received by Regional or District Office _____

Indicate Specific Manual Reference:

☐ DHS Manual Section _____

☐ Food Stamp Manual Section _____

Explain agency decision in relation to complaint and policy: _____

_____

_____

_____

_____

Signature of Agency Representative _____ Signature of Supervisor

District Office

AGENCY USE ONLY

Date received in the hearing office Date of hearing _____

INSTRUCTION FOR COMPLETING DHS-121

This form is used by both the client and the agency representative to:

1. Identify in writing by the client the cause of his/her complaint or grievance; and

2. Identify by the agency representative the policy on which the decision causing the complaint was based.

This form is given to the client at the time s/he decides to appeal an agency decision.

For Food Stamps: A client has 90 days from the date of the Notice of Agency Action to request a hearing.

For All Other Programs: A client has 30 days from the date of the Notice to request a hearing.

Sections I and II

These two sections can be filled out by the client alone, or by the client and agency representative, if the client needs help in completing the form. The section is signed by the person making the complaint.

Section III

After Sections I and II are completed, the agency representative completes Section III, citing the agency policy(ies) with reference to the particular manual sections(s) that was the basis for making the decision. This section is signed by the agency representative and supervisor. The area identifying the area and district are completed. The form is routed promptly to the hearing office at Central Office.

NOTE: When the DHS-121 is completed by the client and mailed directly to Central Office, without being routed through the regional or district office, the hearing office makes a copy of the DHS-121. The original is sent to the regional or district office for completion of Section III. The DHS-121 must be returned to the hearing office at Central Office within seven (7) days.

Legal Help: At the scheduled hearing, you may represent yourself, or be represented by someone else such as a lawyer, a relative, a friend, or another person. If you want free legal help, call Rhode Island Legal Services at 274-2652 (outside the Providence calling area, call toll free at 1-800-662-5034).